HEAT ILLNESS MEDICAL REPORTING FORM

CASUALTY DETAILS

Service Number		Initials		Surname	
Rank		JMES at time of incident			
DoB		DMICP No (if known)		Duty	Exercise / Ops / Sport / Other ……

INCIDENT DETAILS (complete as fully as available information permits)

Date of Incident		Time (Local)	
Activity undertaken:		Location: (exact)	
Clothing Worn:		WBGT Reading	
Equipment Carried:		WBGT Location:	At scene ☐ Locally ☐ Provided by area met ☐ Provided by forecast ☐ Source unknown ☐
Weight Carried:		Date & time taken:	

CLINICAL DETAILS

Casualty Temp		Temperature type? Note – rectal is preferred	Rectal ☐ Oral ☐ Axilla ☐ TM ☐	Time temp was taken (local)?	
Signs and Symptoms					
Clinical Measurements	GCS:		Pulse:		
	Seizure:	Yes / No	B/P:		
Working Diagnosis					
Subsequent Action (Cooling, IVI etc)					
Disposal	Discharged ☐	Refer to SHC for outpatient follow-up ☐			
	Admit Role 1 ☐	Admit Role 2/3 ☐			
	Other ☐	State:			

PREDISPOSING FACTORS (mark all that apply)

Previous Heat Illness	☐	Un-acclimatised	☐	Medication / Drugs:	
Out of date fitness test	☐	Dehydration	☐	Prescribed	☐
Sleep deprived / exhausted	☐	Alcohol (prev 48hr)	☐	Over The Counter	☐
Respiratory Infection or Febrile Illness	☐	Current smoker	☐	Supplements /herbal	☐
Safety briefing received prior to incident	☐			Other	☐

PERSON COMPLETING FORM

Name of MO / NO / Medic		Date	
Signature		Unit	
Consent given by patient for reporting	Yes / No		